

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

08992

CERTIFICATE OF DEATH

Reg. Dist. No. 132

1. PLACE OF DEATH: Frederick
 County: Middleton
 City or town: Middleton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Frederick
 City or town: Middleton (If outside city or town limits, write RURAL and give nearest town)
 Street No.: (If rural, give LOCATION)
 2.(a) If veteran, name war: No

3. (a) FULL NAME James Ross Adams
 4. Sex: Male 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Married
 B.(b) Name of husband or wife: Nora Dix Adams
 7. Birth date of deceased (mo., day, yr.): July 2 1881 B.(c) If alive, give age: 55 years
 8. AGE: Years: 64 Months: 2 Days: 13 If less than one day: hrs: min:
 9. Birthplace: Woodbury - Frederick County Md (Town, county, and state)
 10. Usual occupation: Farmer
 11. Industry or business:
 12. Name of FATHER: Tom Adams
 13. Birthplace: Woodbury Md
 14. Maiden name: Anna Barnes
 15. Birthplace: Frederick, Md
 16. Informant: Mrs. Nora Adams
 Address: Middleton Md
 17. Burial: Burial Date thereof: Sept 18 1945 (Burlal, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory: Lutheran Cemetery
 Location: Middleton, Md
 18. Funeral director: Gladdill Co
 Address: Middleton, Md
 19. Date rec'd by registrar: Sept 18 1945 Name: Marie Gladdill Registrar:
 (Date rec'd by registrar) (Date signed) (M. D. or other)

3. (b) Social Security Number: None

MEDICAL CERTIFICATION

2D. DATE OF DEATH: Sept 15 1945 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1943 to Sept 15 1945 and that I last saw him alive on Sept 15 1945.

Immediate cause of death: Amotrophic Lateral Sclerosis

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

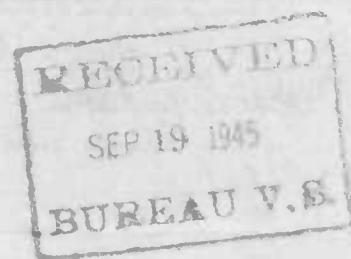
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. E. Harg. M.D.

Address: Middleton Date signed: 9-16-45 M. D. or other:



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BB*

08993

CERTIFICATE OF DEATH

Reg. Dist. No. *141*

1. PLACE OF DEATH:

County *Frederick*City or town *Brunswick*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *3 years*Hospital, Institution, or street address where death occurred: *101 6th Ave*How long in hospital or institution? *—*

3. (a) FULL NAME

*Alie Osborne Baer*4. Sex *Male* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Anna L. Fauble*7. Birth date of deceased (mo., day, yr.) *June 6 1885* 6. (c) If alive, give age *40* years8. AGE: Years *60* Months *3* Days *13* If less than one day *hrs. min.*9. Birthplace *Maryland*
(Town, county, and state)10. Usual occupation *B&O R.R. Co.*11. Industry or business *Hortler*12. Name *John A. Baer*13. Birthplace *Maryland*14. Maiden name *Anna E. Mc Cormick*15. Birthplace *Maryland*16. Informant *Anna L. Baer*Address *Brunswick Md*17. Burial *Burial* Date thereof *Sept 23 1945*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Park Heights*Location *Brunswick Md*18. Funeral directors *C. H. Feets & Son*Address *Brunswick Md.*19. Date rec'd by registrar *Sept. 23 1945*(Date rec'd by registrar) *Emma Martin*
Registrar *Sept. 23 1945*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Frederick*City or town *Brunswick*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *101*

10. 6th Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war *—*

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *September, 19 1945* at *2:15 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 19 1845 to *Sept. 19 1945*and that I last saw her ~~him~~ alive on *Sept. 19 1945*Immediate cause of death *Acute Congestive Heart Failure*DURATION *2 wks.*Due to *—*Due to *—*Other conditions *—*

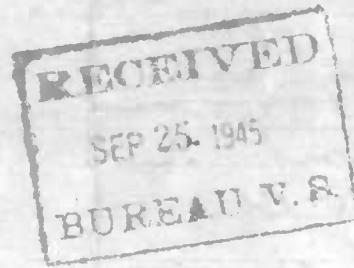
(Include pregnancy within 8 months of death)

Major findings of operations *—* Date of op. *—*Autopsy results *—*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *—* Date of *—*Where did injury occur? *—* (City or town) *—* (County) *—* (State) *—*Injured at home, farm, industry, public place (where?) *—*Means of injury *—* Injured at work? *—*23. SIGNATURE *W. B. Carpenter* M. D. *—*Address *Lowellville, Va.* Date signed *9/20/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3102

CERTIFICATE OF DEATH

08994

131

Reg. Dist. No. 131

1. PLACE OF DEATH:

County

Frederick

City or town

(If outside city or town limits, write RURAL and give nearest town)

2 days

How long in above place of death?

Hospital, institution, or street address where death occurred

Frederick City Hospital

How long in hospital or institution?

2 days

3. (a) FULL NAME

Solomon Emanuel Bair

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

21.

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb. 21, 1875

6. (c) If alive, give age

years

8. AGE:

Years Months Days If less than one day

70

6

22

hrs.

min.

9. Birthplace

near Taneytown Md.

(Town, county, and state)

10. Usual occupation

Telegraph operator

11. Industry or business

Penns. Rail Road

FATHER

12. Name

John E. Bair

MOTHER

13. Birthplace

Penns.

14. Maiden name

Charlotte Green

15. Birthplace

Penns.

16. Informant

Rember H. Bair

Address

Woodsboro Md.

17. Burial

Date thereof

Sept. 16, 1945

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or cemetery

Reform Cemetery

Location

Taneytown Md.

18. Funeral director

Pattell & Hartley

Address

Woodsboro Md.

19. 14 Sept 1945

(Date rec'd by registrar)

Elizabeth G. Heck

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

City or town

Woodsboro (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

None

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 13 1945 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 13 1945 to Sept. 13 1945

and that I last saw him alive on Sept. 13 1945

Immediate cause of death

Hypertensive Cordis Vascula
renal disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

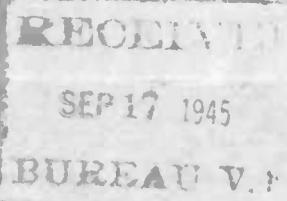
Means of injury

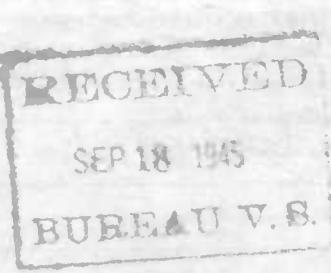
Injured at work?

23. SIGNATURE

Elizabeth G. Heck M. D. or other

Address Woodsboro, Md. Date signed Sept. 14, 1945





Evidence for change of age

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

F.M. G.98 OCT 4 1945

18996

CERTIFICATE OF DEATH

Reg. Diot. No. 137

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 hr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Katheryne M

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Divorced

6. (b) Name of husband or wife

Elmer B. Birely

7. Birth date of deceased (mo., day, yr.)

Nov. 1 - 1866

6. (c) If alive, give age

years

8. AGE:

78

79

10

17

Days

It less than one day

hrs.

min.

9. Birthplace

Ladiesburg Fred Co. Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

MOTHER FATHER

12. Name

M. S. Martz

13. Birthplace

Fred Co. Md

14. Maiden name

Decorah Simonsen

15. Birthplace

Unknown

16. Informant

Mrs. M. S. Schwander

Address

Keymar Md

Burial

Burial

17. (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Mt. Hope Cemetery

Location

Woodsboro Md

18. Funeral director

M. J. Crean Jr.

Address

Thurmont Md

19. (Date rec'd by registrar)

1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Frederick

City or town

Woodsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

200

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 18 1945 at 8⁰⁰ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 9 1945 to Sept 18 1945

and that I last saw her alive on Sept 18 1945

Immediate cause of death

Cerebral Hemorrhage 10 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

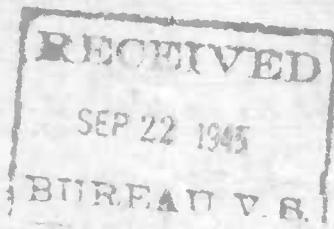
23. SIGNATURE

J. S. Legg

M. D. or other

Address

Elmer Birely Date signed 9-19-45



M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

CERTIFICATE OF DEATH

Reg. Dist. No. 131

68997

1. PLACE OF DEATH:

County

City or town

Frederick
near Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

4 da

3. (a) FULL NAME

Cornelius Harrison Buhman

3. (b) Social Security Number

no

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Single

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)

6. (c) If alive, give age — years

March 7 - 1857

8. AGE:

Years Months Days If less than one day

88 5 26 hrs. min.

9. Birthplace

(Town, county, and state)

Foxville Fred Co Md

10. Usual occupation

Retired

11. Industry or business

12. Name

Harrison Buhman

13. Birthplace

Foxville Md

14. Maiden name

Hannah Poyor

15. Birthplace

Foxville Md

16. Informant

Mrs Chas Stoll

Address

Thurmont Md

17. Burial

Date thereof Sept 5-1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or cemetery

Mt Moriah Cem

Location

Foxville Md

18. Funeral director

M. J. Creasy Son

Address

Thurmont Md

19. H. Sept

19. V. 5

(Date rec'd by registrar)

Elizabeth G. Heck

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Frederick

City or town

Thurmont

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 3 1945 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 29 1945 to Sept 2 1945

and that I last saw him alive on Sept 2 1945

Immediate cause of death

Atherosclerosis

?

DURATION

Due to

Due to

Other conditions

Gastritis

(Include pregnancy within 3 months of death)

Major findings of operations

Anteoply results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Incident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

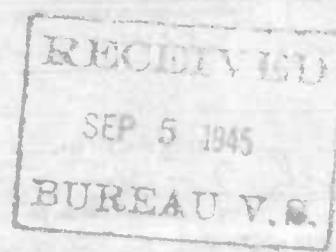
Injured at work?

23. SIGNATURE

J. S. Harp M.D.

M. D. or other

Address Middleton 9-3-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

68999

CERTIFICATE OF DEATH

Reg. Dist. No. 131

MARGIN RESERVED FOR BINDING

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: -

County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Lifetime

Hospital, institution, or street address where death occurred: Emergency Hospital
 How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 456 West South Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

GEORGE A. BURCK

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B.(b) Name of husband or wife Irene A. Basford

7. Birth date of deceased (mo., day, yr.) May 20-1869
 6.(c) If alive, give age years8. AGE: Years Months Days If less than one day
 76 4 2 hrs. min.9. Birthplace Frederick County Maryland
 (Town, county, and state)

10. Usual occupation Plumber

11. Industry or business

12. Name Charles R. Burck

13. Birthplace Frederick County Maryland

14. Maiden name Caroline Stickle

15. Birthplace Frederick County Maryland

16. Informant Mrs. Allen Bartgis

Address 456 W. South Street- Frederick, Md.

17. Burial Date thereof Sept. 25-45
 (Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or cemetery Mount Olivet Cemetery

Location Frederick, Maryland

18. Funeral director C.E.Cline and Son

Address Frederick, Md.

19. Date rec'd by registrar 19.45
 (Date rec'd by registrar)Elizabeth H. Hecht
 Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH September 22nd. 1945 at 7:15 p.m.

21. CERTIFY that death occurred on the date above stated; that I attested deceased from

and that I last saw him alive on Sept. 20, 1945.

Immediate cause of death

Cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

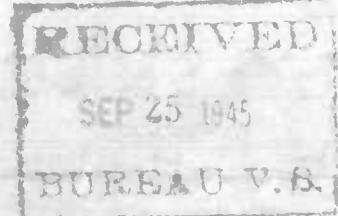
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. or other

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1707

08998

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: Frederick
 County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred: Frederick City Hospital
 Street No. 4 hours
 How long in hospital or institution?

3. (a) FULL NAME
 William Burdette

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced
 Married

6. (b) Name of husband or wife Eleanor Marie Burdette

7. Birth date of deceased (mo., day, yr.) June 3, 1921
 6. (c) If alive, give age 25 years

8. AGE: Years 24 Months 3 Days 4 If less than one day hrs. min.

9. Birthplace Frederick Co., Maryland
 (Town, county, and state)

10. Usual occupation Soldier

11. Industry or business Arthur M. Burdette

MOTHER FATHER 12. Name Arthur M. Burdette
 Maryland

13. Birthplace Maryland
 Effie L. King

14. Maiden name Maryland
 Arthur M. Burdette

15. Birthplace Mt. Airy, Md.

16. Informant Mt. Airy, Md.
 Address

17. Burial Date thereof 9-10-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Damascus Pine Grove,
 Mt. Airy, Montgomery Co. Md.

Location
 18. Funeral director C.M. Waltz
 Address Winfield, Md.

19. 8 - Sept 1945 - Elizabeth G. Hede
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Mt. Airy
 (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)
 2. (a) If veteran, name war World War II

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1945 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. 117 dead to 1945
 alive on Sept 7 1945

Immediate cause of death

Fracture of skull
 shock

Due to

Auto accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. accident Date of 9-7-45

Where did injury occur? Poplar Springs Howard Md (City or town) (County) (State)

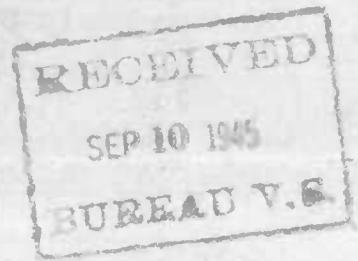
Injured at home, farm, industry, public place (where?) Route #4005

Means of injury Auto Injured at work? no

23. SIGNATURE P. W. Baer Deputy Med Ex

M. D. or other

Address Frederick, Md. Date signed 9-7-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

CERTIFICATE OF DEATH

69900

Reg. Dist. No.

131

1. PLACE OF DEATH: Frederick
 County: Frederick
 City or town: Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 years.
 Hospital, institution, or street address where death occurred: Frederick City Hospital
 How long in hospital or institution? 7 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Maryland County: Frederick
 City or town: Woodsboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.:
 (If rural, give LOCATION)
 2.(a) If veteran, name war: None

3. (a) FULL NAME

CHESTER ALLEN ARTHUR BURRAS

4. Sex: Male	5. Color or race: White	6.(a) Single, married, widowed, or divorced: Married
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8.(b) Name of husband or wife: Mollie Smith Burras

7. Birth date of deceased (mo., day, yr.): October 17, 1885

8. AGE: Years: 59	Months: 11	Days: 5	It less than one day: hrs.	min.
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9. Birthplace: Frederick, Maryland
 (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: " "

12. Name: Daniel Burras

13. Birthplace: New York

14. Maiden name: Barbara Ann Fauble

15. Birthplace: Burkettsville, Maryland

16. Informant: Charles Burras

Address: Frederick, Maryland

17. Burial: Date thereof: Sep. 26, 1945
 (Burial, cremation, or removal. When?)

Cemetery or cemetery: Mt. Olivet Cemetery

Location: Frederick, Maryland

18. Funeral director: C. E. Cline & Son

Address: Frederick, Maryland

19. Date rec'd by registrar: Sept. 24, 1945
 (Date rec'd by registrar)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 23, 1945, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1945 to Sept. 23, 1945, and that I last saw him alive on Sept. 23, 1945.

Immediate cause of death: *Paroxysmal asthma*

Due to: *Paroxysmal asthma*

Due to: *Paroxysmal asthma*

Other conditions: *Paroxysmal asthma*

(Include pregnancy within 3 months of death)

Major findings or operations: *Paroxysmal asthma*

Date of op.: *Paroxysmal asthma*

Autopsy results: *Paroxysmal asthma*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: *Paroxysmal asthma*

Date of: *Paroxysmal asthma*

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: *J. D. Maxon M.D.*

M. D. or other: *J. D. Maxon M.D.*

Date signed: *Sept. 24, 1945*

Address: *J. D. Maxon M.D.*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

09001

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
County. Frederick
City or town. Frederick-Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 16 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State. Maryland County. Frederick

City or town. Frederick (If outside city or town limits, write RURAL and give nearest town)

Street No. 427 Middle Alley

(If rural, give LOCATION)

2.(a) If veteran, name war. None

3. (a) FULL NAME

FLORENCE REBECCA CANN

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	W

6.(b) Name of husband or wife. Blenn G. Cann

7. Birth date of deceased (mo., day, yr.) October 23, 1881

6.(c) If alive, give age years

8. AGE: Years	Months	Days	It less than one day
63	10	29	hrs. min.

8. Birthplace. Frederick-Frederick-Maryland

(Town, county, and state)

10. Usual occupation. Housewife

11. Industry or business

12. Name. Horace T. Walker

13. Birthplace. Frederick County Maryland

14. Maiden name. Aria Anna Smith

15. Birthplace. Frederick County Maryland

16. Informant. Miss I. Virginia Lidie R. N.

Address. Emergency Hospital-Fred'k, Md.

17. Burial. Date thereof. 9/24/45

(Burial, cremation, or removal. Which?)

Cemetery or crematory. Fairview Cemetery

Location. Frederick, Maryland

18. Funeral director. M. R. Etchison and Son

Address. Frederick, Maryland

19. 24-Dept. 1945
(Date rec'd by registrar)Elizabeth G. Heck
Registrar3. (b) Social Security Number
None

MEDICAL CERTIFICATION

20. DATE OF DEATH. September 22, 1945, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 6, 1945, to September 22, 1945, and that I last saw her alive on September 21, 1945.

Immediate cause of death.

Coronary Arterial Disease

DURATION

3 years

Due to.

Due to.

Other conditions. Acute Coronary Disease

edema

(Include pregnancy within 3 months of death)

Major findings or operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of.

Where did injury occur? (City or town) (County) (State)

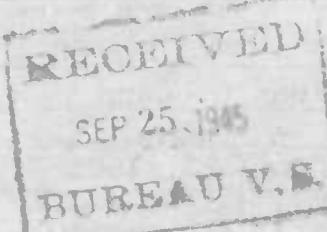
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE. H. Lawrence Zehring, M. D.

M. D. or other
Address. Frederick, Maryland Date signed. 9-24-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 892

09002

CERTIFICATE OF DEATH

Reg. Dist. No. 132

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

2 years

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Lewis Albert Cline

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of husband or wife.....

Alice Cline

7. Birth date of deceased (mo., day, yr.)

Nov. 5, 1896

6. (c) If alive, give age.....

65

years

8. AGE:

Years 68

Months 9

Days 26

If less than one day

hrs.

min.

9. Birthplace.....

Myersville, Frederick County Md.

(Town, county, and state)

10. Usual occupation.....

Retired Farmer

11. Industry or business

Thos. Cline

12. Name

Thos. Cline

13. Birthplace

Myersville Md.

14. Maiden name.....

Catherine Summers

15. Birthplace

Myersville Md.

16. Informant.....

Mrs. Mary Cline

Address

Middletown, Md.

17. Burial

Date thereof Sept 4 1945

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory.....

St. Matthew Cemetery

Location.....

Middletown, Md.

18. Funeral director.....

Gladhill Co.

Address

Middletown, Md.

19. 1945

(Date rec'd by registrar)

Date of death

1945

Date signed

Sept 4/5

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State.....

Maryland

County.....

Frederick

City or town.....

Middletown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

East Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

No

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 1, 1945 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 27, 1945, to Sept 1, 1945, and that I last saw him alive on Sept 1, 1945.

Immediate cause of death.....

cerebral hemorrhage

DURATION

6 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

H. V. St. John, M.D.

M. D. or other

Address.....

Myersville, Md.

Date signed

Sept 4/5



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09003

B1-20

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Walkersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Josiah Croom

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white marriedB. (b) Name of husband or wife Ellen Harriet Croom

7. Birth date of deceased (mo., day, yr.)

Jan 12, 1861

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Frederick Co.

(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

12. Name Solomon Croom

13. Birthplace

Fred. Co.14. Maiden name Mary Catherine Kanode

15. Birthplace

Fred. Co.

16. Informant

Mrs. Josiah Croom

Address

Walkersville

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept 23 1945
(month) (day) (year)

Cemetery or crematory

Union Chapel

Location

Ne. Liberty town4 C. Barton

18. Funeral director

Walkersville

Address

19. 22 Sept 1945
(Date rec'd by registrar)Elizabeth G. Heck

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

Fred. CoCity or town Walkersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 20, 45 19 5 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Aug 1, 1945 to Sept 20, 1945 1945
and that I last saw him alive on Sept 20, 45 1945

Immediate cause of death

Hypertensive Cardi. Vascula. Renal disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Samuel E. Gasterday

M. D. or other

Address Walkersville, MdDate signed Sept 22, 45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46d+

CERTIFICATE OF DEATH

09064

131

Reg. Dist. No.

1. PLACE OF DEATH:

County

Frederick

City or town

Frederick RFD 5

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

18 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Mae E. Decker

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or

William Decker

7. Birth date of deceased (mo., day, yr.)

Feb. 18, 1891

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

74 7 10 hrs min.

9. Birthplace

(Town, County, and state)

Pittsburgh, Penn.

10. Usual occupation

Saleswoman

11. Industry or business

Edward's Check

MOTHER FATHER

12. Name

Edward's Check

13. Birthplace

Pittsburgh, Pa.

14. Maiden name

Margaret Orr

15. Birthplace

Pittsburgh, Pa.

16. Informant

Mrs. Richard N. Wallace

Address

Frederick, Md. RFD 5

17. Burial

McClint

Cemetery or crematory

Frederick, Md.

Location

Gladhill Co.

18. Funeral director

Middletown, Md.

Address

Middletown, Md.

19. I - Qd

Eliz. + by Heck

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Frederick

City or town

Frederick

Street No.

RFD 5

2.(a) If veteran, name war

No

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28, 1945, at 6:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Martha 3, 1945, to Sept 28, 1945

and that I last saw her alive on Sept 28, 1945

Immediate cause of death

Carcinoma of Rectum & Bladder

DURATION

6 mo. 1

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

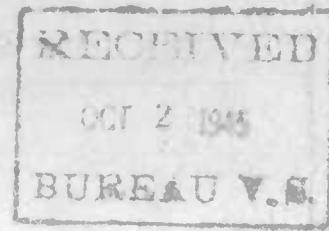
Means of injury

Injured at work?

23. SIGNATURE

B. L. Thomas M. D. or other

Address Frederick, Md. Date signed 10/11/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

08991

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

Frederick

County

Frederick-Rural R. F. D. #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Near Mount Pleasant

How long in hospital or institution?

3. (a) FULL NAME

CHARLES ELMER EADER, JR.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M W W

8. (b) Name of husband or wife

Ida Coburn Rager

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years

September 7, 1887

8. AGE: Years Months Days If less than one day

58 0 12 hrs. min.

9. Birthplace

Frederick-Frederick-Maryland

(Town, county, and state)

10. Usual occupation

Cabinet Maker

11. Industry or business

Bowers Lumber Company

12. Name

Charles E. Eader, Sr.

13. Birthplace

Frederick County Maryland

14. Maiden name

Mary Quinn

15. Birthplace

Frederick County Maryland

16. Informant

Miss Charlotte E. Eader

Address

311 E. 3rd St., Frederick, Md.

17. Burial

Date thereof

9/22/45

(Burial, cremation, or removal. Which)

(month) (day) (year)

Cemetery or crematory

Mount Olivet Cemetery

Location

Frederick, Maryland

18. Funeral director

M. R. Etchison and Son

Address

Frederick, Maryland

19. Date

Sept 1945

(Date rec'd by registrar)

Elizabeth G. Hech

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 311 East Third Street

(If rural, give LOCATION)

None

2.(a) If veteran, name war

3. (b) Social Security Number

214-10-1707

MEDICAL CERTIFICATION

4:30 P

September 19th 1945 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19, to 19

and that I last saw him alive on September 19, 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

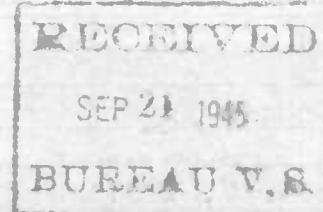
Elizabeth G. Hech, M.D. or other

Frederick, Maryland

Date signed 9/20/45

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RECEIVED BY THE UNITED STATES GOVERNMENT



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09005

170-2

CERTIFICATE OF DEATH.

Reg. Dist. No.

637

1. PLACE OF DEATH:

County Frederick

City or town Unionville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

State Highway #26

How long in hospital or institution?

3. (a) FULL NAME

DEWOLFE CONRADE EBERSTEIN

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

W

M

6.(b) Name of husband or wife

Reta Kartez

7. Birth date of deceased (mo., day, yr.)

January 17, 1918

6.(c) If alive, give age

23

years

8. AGE:

Years

Months

Days

If less than one day

27

8

2

hrs.

min.

9. Birthplace

Boston, Mass.

(Town, county, and state)

10. Usual occupation

Electrician

11. Industry or business

MOTHER FATHER 12. Name

M. C. Eberstein

13. Birthplace

Nebraska

14. Maiden name

Marian DeWolfe

15. Birthplace

Mass.

16. Informant

M. C. Eberstein

Address

Baltimore, Maryland

17. Burial

Date thereof Oct. 3, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Druid Ridge,

Location

Pikesville, Md.

18. Funeral director

M. R. Etchison and Son

Address

Frederick, Maryland

19. Oct 3

19 45

(Date rec'd by registrar)

A. Etchison

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Texas

County

City or town Huston

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

481-14-0840

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1945 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw him alive on Sept 29 1945
Immediate cause of death: Crouping of the lungs
Chest & abdomen, fat tumor
7 days.

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? Carroll, Frederick, Frederick

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Moat 26 05

Means of injury

Auto

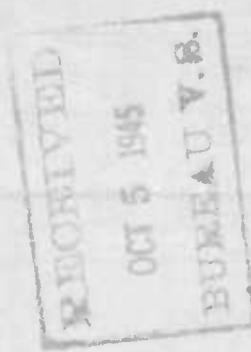
Injured at work?

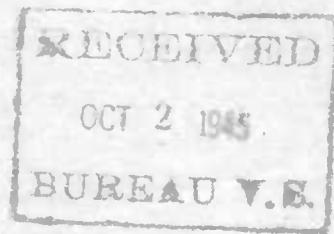
23. SIGNATURE

R. W. Barr

M. D. or other

Address Frederick, Md. Date signed 9-20-45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

19007

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH: **Frederick**
 County.....
 City or town..... **State Sanatorium, Maryland**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **Since 6/15/45**
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution?..... **Since 6/15/45**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... **Maryland** County.....
 City or town..... **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **1917 N. Patterson Park Ave.**
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME
Clement Floyd

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
Male	White	Separated		
6.(b) Name of husband or wife..... Ross Floyd				
6.(c) If alive, give age..... years				
7. Birth date of deceased (mo., day, yr.) June 24, 1889				
8. AGE:	Years	Months	Days	If less than one day
	56	2	28 hrs. min.

9. Birthplace..... **Baltimore, Maryland**
 (Town, county, and state)

10. Usual occupation..... **Huckster**

11. Industry or business

MOTHER FATHER	12. Name..... Charles Floyd
	13. Birthplace..... Baltimore, Md.
MOTHER	14. Maiden name..... ?
	15. Birthplace..... ?
16. Informant..... Deceased	

17. Burial..... **Burial** Date thereof **Sept. 25, 1945**
 (Burial, cremation, or removal. Which?) **Baltimore, Md.**
 Cemetery or crematory..... **Baltimore, Md.**
 Location..... **Baltimore, Md.**

18. Funeral director..... **Not Required**

Address..... **19. 9/21/45**

(Date rec'd by registrar) **19.** (Date signed) **9/21/45**

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **September 21** 19. 45, at **3:35 P.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **June 15** 19. 45, to **Sept. 21** 19. 45, and that I last saw him alive on **September 21** 19. 45.Immediate cause of death..... **Pulmonary Tuberculosis** DURATION **9 Mos.**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

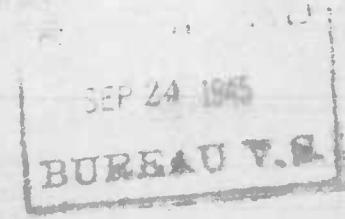
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... **John Lynn** M. D. or other **X**Address..... **State Sanatorium, Md.** Date signed **9/21/45**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 520

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
Frederick
County

City or town
Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Life

Hospital, Institution, or street address where death occurred:
Frederick City Hospital

How long in hospital or institution?

3. (a) FULL NAME

WILLIAM EDWARD GOODMAN

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	C	S

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.) June 19, 1937
6. (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
8	3	3	hrs. min.

9. Birthplace
Frederick-Frederick-Maryland

(Town, county, and state)

10. Usual occupation
Student

11. Industry or business
Public School

12. Name
Harry E. Goodman

13. Birthplace
Frederick County Maryland

14. Maiden name
Rebecca Hamilton

15. Birthplace
Montgomery County Maryland

16. Informant
Harry E. Goodman

Address
522 Klineharts Alley, Fred'k, Md.

17. Burial
(Burial, cremation, or removal where)
Fairview Cemetery

Cemetery or crematory
Frederick, Maryland

18. Funeral director
M. R. Etchison and Son

Address
Frederick, Maryland

19. *25 West* 19. y-
(Date rec'd by registrar)

Elizabeth B. Heile
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State
Maryland
County

City or town
Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No.
522 Klineharts Alley
(If rural, give LOCATION)

2.(a) If veteran, name war
None

3. (b) Social Security Number
None

MEDICAL CERTIFICATION

20. DATE OF DEATH
September 22, 1945 2 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Sept 1, 45 1945 to *Sept 22, 1945*

and that I last saw him alive on *Sept 22, 1945*

Immediate cause of death
Rheumatic fever

DURATION

Due to

Due to

Other conditions
Rheumatic Paroxysms

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

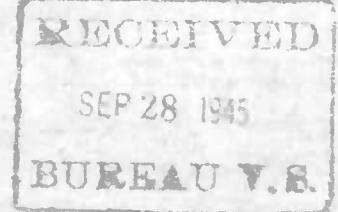
23. SIGNATURE
Ed Lester Jr. M. D.

M. D. or other

Address
Walkersville Frederick, Maryland Date signed 9-24-45

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ILLINOIS STATE LIBRARY



MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

M

1. PLACE OF DEATH

County

Frederick

90

09009

Registration Dist. No. 140

Village or City

Rural near Detour

No.

St.

Ward

Length of residence in city or town where death occurred 86 yrs. 6 mos. 19 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

(a) Residence: No.

Alice May Grossnickle

Near Detour St. Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (write the word)

Widowed

6e. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Tilghman Luther Grossnickle

6. DATE OF BIRTH (month, day, end year)

Feb. 23, 1859

7. AGE

Years
86Months
6Days
19If LESS than
1 day, _____ hrs.
or _____ min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)
(State or country)

Rural near Detour

Frederick Co. Md.

13. NAME

Joshua Cernack.

14. BIRTHPLACE (city or town)
(State or country)

Detour

Maryland

15. MADIOEN NAME

Amanda Eyer.

16. BIRTHPLACE (city or town)
(State or country)

Detour

Maryland

17. INFORMANT
(Address)

Mrs. Raymond A. Balsagh

Detour Md.

18. BURIAL, CREMATION, OR REMOVAL

Burial

Hagerstown

Date Sept. 15, 1945

19. UNDERTAKER
(Address)

M. J. Presqueaston

Hagerstown

Md.

20. FILED

9/14

, 1945

L. L. Donnell

Registrar

21. DATE OF DEATH

September 12, 1945
(Month) (Day) (Year)

22. I HEREBY CERTIFY. That I attended deceased from

Jan. 20, 1945, to Sept. 12, 1945

I last saw her alive on Sept. 12, 1945; death is said to have occurred on the date stated above, at 4:00 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Ovarian Myocarditis
Date of onset
32 weeks

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury _____, 19____

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) *John O. Donnell* M. D.(Address) *Hagerstown, Md.*

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	RECEIVED	Date of onset
Run over by street car	SEP 17 1927	1 week ago
Peritonitis	RECEIVED	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16

CERTIFICATE OF DEATH

09010

Reg. Dlat. No. 134

1. PLACE OF DEATH: Frederick City Hospital
County: Frederick

City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Mrs. Catherine L. Hahn

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced widow

6.(b) Name of husband or wife C. Guy Hahn

7. Birth date of deceased (mo. day, yr.) Oct. 30, 1884 8. (c) If alive, give age years

8. AGE: Years 60 Months 10 Days 20 If less than one day hrs. min.

9. Birthplace Frederick Co.
(Town, county, and state)

10. Usual occupation housework

11. Industry or business

12. Name Albert Saylor
13. Birthplace Md

14. Maiden name Susan Hoffman

15. Birthplace Md

16. Informant Carl T. Hahn

Address Taneytown R#2

17. burial Date thereof Sept. 21, 1945
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or cemetery Keysville

Location Keysville, Md.

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. Sept. 20 1945 Elizabeth G. Hahn
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Carroll

City or town Taneytown Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1945 1945-1945-1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 to 1945 1945 to Sept 19 1945 1945 and that I last saw her alive on Sept 13 1945 1945

Immediate cause of death S-hock following
Amputation of right leg
fall from great height

Due to falling by injury on
Sept 5, 1945 1945

Left in hospital in care of Dr.
Edward P. F. Burns - Dr. Burns M.D.

Other conditions shakes 14 days

DURATION

14 days

1 year

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident Accident Date of Sept 5 1945 1945

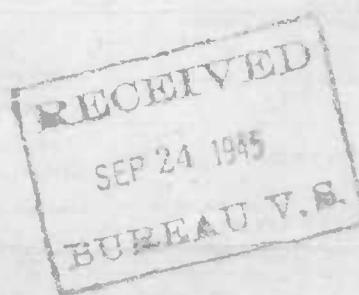
Where did injury occur? Md. Taneytown Carroll Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fell upon Right leg Injured at work? No
going to spring for bucket of water

23. SIGNATURE S. M. Bemmer M.D. or other

Address Taneytown Md. Date signed Sept 20th 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

69011

CERTIFICATE OF DEATH

Reg. Dist. No. 136

1. PLACE OF DEATH:
County..... Frederick

City or town..... Frederick-Rural R. F. D. #2
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 Years

Hospital, institution, or street address where death occurred:
Near Frederick Junction

How long in hospital or institution?

3. (a) FULL NAME

GEORGE WASHINGTON HALLER, SR.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

8.(b) Name of husband or wife..... Nettie M. Dixon

7. Birth date of deceased (mo., day, yr.)..... January 25, 1869
(c) If alive, give age 70 years

8. AGE: Years Months Days If less than one day

76	7	10	hrs. min.
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9. Birthplace..... Frederick-Frederick-Maryland
(Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business

MOTHER / FATHER	12. Name..... John Haller
-----------------	---------------------------

MOTHER / FATHER	13. Birthplace..... Frederick County Maryland
-----------------	---

MOTHER	14. Maiden name..... Mary Lidie
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MOTHER	15. Birthplace..... Frederick County Maryland
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16. Informant..... Mrs. Nettie D. Haller

Address..... R. F. D. #2-Frederick, Maryland

17. Burial

(Burial, cremation, or removal. Which?)..... Date thereof 9/7/45
(month) (day) (year)

Cemetery or crematory..... Mount Olivet Cemetery

Location..... Frederick, Maryland

18. Funeral director.

Address..... M. R. Etchison and Son

Address..... Frederick, Maryland

19.-Date..... 1945-
(Date rec'd by registrar)

J. O. Hendrickson
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Frederick

City or town..... Frederick-Rural R. F. D. #2
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Near Frederick Junction
(If rural, give LOCATION)

2.(n) If veteran, name war..... None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 5 1945 at 1:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. 17 dead on Sept 6 1945.

Immediate cause of death..... Coronary seclum

Due to..... Atmoushous
DURATION 2 hrs
10 years

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... P. W. Barr Deputy Ex.

M. D. or other.....

Address..... Frederick, Md Date signed..... Sept 6, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH.

2411 N. Charles St., Baltimore

09012

CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH:

County FrederickCity or town Rehoboth Beach, Del.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Catherine Hamburg

3. (b) Social Security Number

none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

October 3, 1860

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

84

11

18

hrs.

min.

9. Birthplace

Chambersburg, Pa.

(Town, county, and state)

10. Usual occupation

Waitress

11. Industry or business

Home

MOTHER FATHER

12. Name Frank Hamburg

13. Birthplace

Unknown

MOTHER

14. Maiden name Sarah Hamburg

15. Birthplace

Unknown

16. Informant

Mrs. Nancy Penn

Address

Rocky Ridge, Md.

17. Burial

Date thereof Sept. 16, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Mt. Taber

Location

Rocky Ridge, Md.

18. Funeral director

M. F. Pendleton & Son

Address

Thurmont, Md.

19. Sept. 16, 1945

(Date rec'd by registrar)

Blanche S. Egger
Deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State DelawareCounty FrederickCity or town Rehoboth Beach, Del.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 14

19

430 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 12 1945 to Sept 14 1945 and that I last saw her alive on Sept 13 1945

Immediate cause of death

cardiac decompression

DURATION

3 mo

Due to chronic myocarditis several years

DURATION

arteriosclerosis - several years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

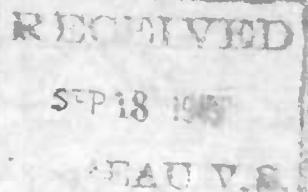
23. SIGNATURE

W. R. Cagle MD

M. D. or other

Address

Summit Bay Rd. Date signed 9-14-45



PLEASE WRITE PLAINLY, WITH UNADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

09613

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
County Frederick
City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Months

Hospital, Institution, or street address where death occurred:

136 West All Saint Street

How long in hospital or institution? _____

3. (a) FULL NAME

DIANNA JANE LAVERA HILL

4. Sex <u>F</u>	5. Color or race <u>C</u>	6. (a) Single, married, widowed, or divorced <u>S</u>
-----------------	---------------------------	---

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) May 30, 1945

6. (c) If alive, give age _____ years

8. AGE: Years <u>0</u>	Months <u>3</u>	Days <u>25</u>	If less than one day
hrs. _____	min. _____		

9. Birthplace Frederick R. D. -Frederick-Maryland
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER Wesley John Ross

13. Birthplace Baltimore, Maryland

MOTHER Nellie Virginia Hill

15. Birthplace Frederick County Maryland

18. Informant Nellie V. Hill

Address 136 W. All Saint St., Fred'k, Md.

17. Burial Date thereof 9/26/45

(Burial, cremation, or removal. Which) Ebenezer Cemetery

Cemetery or location Near Urbana, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. Sept 25 Date rec'd by registrar Elizabeth G. Heels

(Date rec'd by registrar) 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 136 West All Saint Street

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1945 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 22 1945 to Sept 25 1945

and that I last saw her alive on Sept 22 1945

Immediate cause of death

Congenital heart

DURATION

One month

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, Industry, public place (where?)

Means of injury

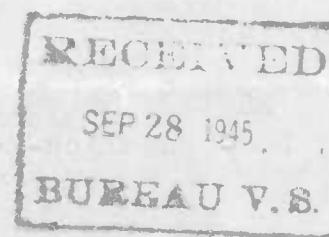
Injured at work?

23. SIGNATURE

R. W. Barr

M. D. or other

Address Frederick, Maryland Date signed 9-25-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B2

09014

CERTIFICATE OF DEATH

Reg. Dist. No. 134

1. PLACE OF DEATH:

County FrederickCity or town Emmitsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Catherine Hopp

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FemaleWhiteWidow6. (b) Name of husband or wife Harry Hopp

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 5, 1866

8. AGE: Years

Months

Days

If less than one day

7946

hrs.

min.

9. Birthplace Frederick Co., Maryland
(Town, county, and state)10. Usual occupation Housekeeper

11. Industry or business

12. Name John Dukehart13. Birthplace Frederick County, Md.14. Maiden name Catherine Smith15. Birthplace Ireland16. Informant Rose M. BealeAddress Emmitsburg, Md.17. Burial St. Joseph's Catholic
(Burial, cremation, or removal. Which?) Date thereof Sept. 14, 1945
(month) (day) (year)Cemetery or crematory St. Joseph's CatholicLocation Emmitsburg, Md.18. Funeral director S. L. AllisonAddress Emmitsburg, Md.19. Sept. 13, 1945
(Date rec'd by registrar)

W. L. Shuf

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Emmitsburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

No

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 11

1945

at 10:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1930

to

Sept 11

1945

and that I last saw her alive on Sept 11

1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

6 daysDue to Hypertensive cardio
vascular disease

Due to

several years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

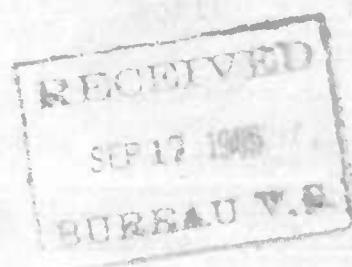
Injured at work?

23. SIGNATURE

W. L. Odde

M. D. or other

Address Emmitsburg, Md. Date signed Sept 13, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1472

09015

CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH:

County Frederick
 City or town Rural Location in Thurmont
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Robert Allen Husley

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
--------------------	-------------------------------	--

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) March 26, 1945
 8. AGE: Years 5 Months 11 Days It less than one day

9. Birthplace Foxville, Frederick Co., Md.
 (Town, county, and state)

10. Usual occupation.

11. Industry or business

FATHER 12. Name Robert Husley
 13. Birthplace Foxville, Md.
 MOTHER 14. Maiden name Mary Walter
 15. Birthplace Frederick, Maryland

16. Informant Mrs. Robert Husley
 Address Lanty, Md.

17. Burial Burial Date thereof Sept. 7, 1945
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Cathedral
 Location Mad. Garfield, Md.

18. Funeral director M. L. Clegg & Son
 Address Thurmont, Md.

19. Sept. 8, 1945
 (Date rec'd by registrar) Blanche S. Eyer
 Deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Foxville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 200
 (If rural, give LOCATION)

2. (a) If veteran, name war WWII

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1945, at 21.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 7, '45 to Sept. 7, '45 1945, and that I last saw him alive on Sept. 7, '45 1945.

Immediate cause of death Gastroenteritis Acute DURATION 5 days

Due to Seal extraction

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

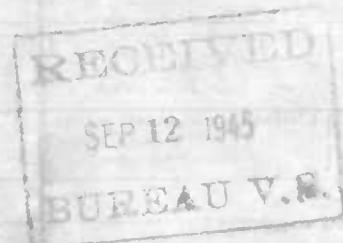
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. A. Bixby M. D. or other

Address Towson - Md. Date signed 9/8/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

09016

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

8 Years

How long in above place of death?

Hospital, institution, or street address where death occurred:

200 Block West South Street

How long in hospital or institution?

3. (a) FULL NAME

RALPH J. JOHNSON

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	C	S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) September 12, 1930

8. AGE: Years Months Days If less than one day
14 11 14 hrs. min.9. Birthplace Frederick County Maryland
(Town, county, and state)

10. Usual occupation Student

11. Industry or business Public School

12. Name Henry Johnson

13. Birthplace Frederick County Maryland

14. Maiden name Mary Palmer

15. Birthplace Frederick County Maryland

16. Informant George Ambush

Address 300 Madison St., Frederick, Md.

17. Burial Date thereof 9/10/45

(Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory Fairview Cemetery

Location Frederick, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 8 Dept 1945
(Date rec'd by registrar)Elizabeth G. Heck
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 Madison Street

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1945 at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. 1/11 died 1945 to 1945

Immediate cause of death

Crush injury of rt chest

+ internal injuries

Run over by tractor

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of 9.6.45

Where did injury occur? Frederick, Frederick Md.

(City or town) (County) (State)

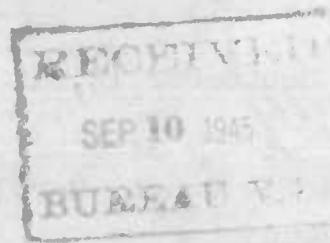
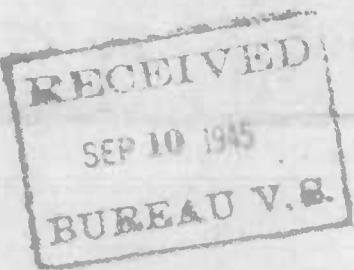
Injured at home, farm, industry, public place (where?) W. South St.

Means of Injury Run over by tractor Injured at work no

Property used

23. SIGNATURE R. W. Rose Date signed 9.6.45.

Address Frederick, Md. M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69017

131

Reg. Dist. No.

1. PLACE OF DEATH:

County FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Frederick City HospitalHow long in hospital or institution? 1 day

3. (a) FULL NAME

Laura Anna Key4. Sex F 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Wilson Skey7. Birth date of deceased (mo., day, yr.) Sept. 30, 18718. (c) If alive, give age years8. AGE: Years 73 Months 11 Days 19 If less than one day hrs. min.9. Birthplace Libertytown Md.
(Town, county, and state)10. Usual occupation Domestic11. Industry or business House work12. Name John A. Thomas13. Birthplace Frederick Co. Md.14. Maiden name Elijah Roberts15. Birthplace Frederick Co. Md.16. Informant James A. SkeyAddress Walkersville Md.17. Burial Burial Date thereof Sept. 23, 1945

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory John WesleyLocation Libertytown Md.18. Funeral director Powell & HartleyAddress Woodsboro Md.19. 21-Dept 1945 Date rec'd by registrar Elizabeth Heck

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Libertytown (If outside city or town limits, write RURAL and give nearest town)Street No. none (If rural, give LOCATION)2.(a) If veteran, name war none3. (b) Social Security Number none

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19, 1945 at 8:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

end dead to 19
and that I last saw him alive on Sept 19 1945

Immediate cause of death

Fracture of skull
cutting injury to chest
Due to hacchlings of face
+ severeDue to Auto accident

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

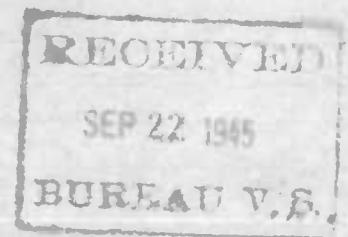
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-19-45Where did injury occur Liberty Frederick Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Rail 26Means of injury Auto Injured at work? No23. SIGNATURE R. R. Skey

M. D. or other

Address Frederick Md. Date signed Sept 20, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

Reg. Dist. No. 134

1. PLACE OF DEATH

Frederick

County

City or town

Emmitsburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

3 months

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Susan Cecelia Kruse

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

widow

6. (b) Name of husband or wife

Lewis Kruse

7. Birth date of deceased (mo., day, yr.)

December 17, 1859

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

85

8

19

hrs.

min.

9. Birthplace

Frederick Co., Md.

(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

MOTHER

12. Name

Isaac E. Bowers

FATHER

13. Birthplace

Frederick Co., Md.

MOTHER

14. Maiden name

Cecelia Eek

MOTHER

15. Birthplace

Adams Co., Penna

16. Informant

Mrs. Rose Peterson

Address

Emmitsburg, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

St. Anthony's Shrine Cemetery

Location

Emmitsburg, Md., R.F.D.

18. Funeral director

S. L. Allison

Address

Emmitsburg, Md.

19. (Date received by registrar)

Sept 11-7, 1975

M. F. Shantz
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Frederick

City or town

Rural (If outside city or town limits, write RURAL and give nearest town)

Street No.

Emmitsburg, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 6, 1975

at

4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 to Sept 6, 1975

19

45

and that I last saw her alive on Sept 5, 1975

19

45

Immediate cause of death

Arteriosclerotic
cardio vascular
disease - several years

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. P. Cade M.D.

M. D. or other

Address

Emmitsburg, Md.

Date signed

9-6-45

RTIAMS TO TELMTRASS STATE OF ILLINOIS

RECEIVED - 1945 - 9-12-51

RTIAMS TO TELMTRASS

RECEIVED - 1945 - 9-12-51

RECEIVED

SEP 12 1945

BURKAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

09019

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
County Frederick
City or town Frederick - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. Lincoln Apt's. Pheobus Ave.
(If rural, give LOCATION)
None

3. (a) FULL NAME

DWIGHT DELNORE LEAKS

4. Sex <u>male</u>	5. Color or race <u>colored</u>	6. (a) Single, married, widowed, or divorced <u>single</u>
--------------------	---------------------------------	--

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Sept. 19th., 19458. AGE: Years 0 Months 0 Days 10 II less than one day hrs. min.9. Birthplace Frederick, Frederick, Md.
(Town, county, and state) ✓

10. Usual occupation. ✓

11. Industry or business

FATHER Joseph T. Leaks,
12. Name Dela, Md.
13. BirthplaceMOTHER Mary Weedon
14. Maiden name Doubs, Md.
15. Birthplace16. Informant Joseph T. Leaks,
Address Lincoln Apt's, Frederick, Md.17. Burial Methodist Cemetery,
(Burial, cremation, or removal) Dela, Dickerson, Md. R. D.
Date thereof Oct. 1, 1945
(month) (day) (year)Cemetery or crematory
Location M. R. Etchison & Son,18. Funeral director
Address Frederick, Md.19. 29th Sept 1945
(Date rec'd by registrar) Elizabeth H. Tech
Registrar3. (b) Social Security Number none

MEDICAL CERTIFICATION

Sept. 29th., 1945 at 1:30 P.M.

20. DATE OF DEATH
I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 26, 45 1945 to Sept 29 1945
and that I last saw h. alive on Sept 29, 45 1945Immediate cause of death Fracture of bronch DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. E. Foster Day M.D.M. D. or other MD Date signed 9/30/45Address Walkersville, Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(B-3)*

CERTIFICATE OF DEATH

Reg. Dist. No. *139**09020*

1. PLACE OF DEATH:

County **Frederick**City or town **State Sanatorium, Md.**
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? **Since 8/22/45**

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Since 8/22/45

3. (a) FULL NAME

De Warren Metz

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug. 21, 19016. (c) If alive, give age **years**

8. AGE: Years

44

Months

0

Days

20

If less than one day

hrs.**min.**

9. Birthplace

Cumberland, Md.
(Town, county, and state)

10. Usual occupation

Cook

11. Industry or business

12. Name **Cleve Metz**

13. Birthplace

W. Va.

14. Maiden name

Iva M. Brooks

15. Birthplace

Martinsburg, W. Va.

16. Informant

Deceased

Address

17. **Burial** *Burial* Date thereof **Sept. 13, 1945**
(Burial, cremation, or removal. Which?) *Burial* (month) (day) (year)Cemetery or crematory **Rose Hill**Location **Cumberland, Md.**18. Funeral director **John C. Chapman**Address **7115/45**19. (Date rec'd by registrar) **19**

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Alleghany**City or town **Cumberland**
(If outside city or town limits, write RURAL and give nearest town)Street No. **323 Bedford St.**
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 10** 1945, at **9 A.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **August 22** 1945, to **Sept. 10** 1945, and that I last saw him **alive** on **Sept. 10** 1945.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

4 Mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *J. B. Lipp*M. D. *John B. Lipp*Address **State Sanatorium, Md.** Date signed **9/10/45**



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

09021
307
Reg. Dist. No.

1. PLACE OF DEATH:

County FrederickCity or town Brunswick, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Schnauffers HospitalStay in hospital or Inst. (yrs., or mos., or days) 3 moStay in this community (yrs., or mos., or days) 67 yrs

3. (a) FULL NAME

Frederick George Mirley4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower6. (b) Name of husband or wife Sadie Ann Mirley7. Birth date of deceased (mo., day, yr.) March 21 18788. AGE: Years 67 Months 6 Days 0 If less than one day hrs. 0 mln.9. Birthplace Sandy Hook, Md.
(Town, county, and state)10. Usual occupation Track Forman11. Industry or business B. & O. R. R. Co.12. Name George Frederick Mirley13. Birthplace Not Known14. Maiden name Nora Rosina Hammond15. Birthplace Not Known16. Informant William F. MirleyAddress Sandy Hook, Md. R.R. # 117. Burial Burial Date thereof Sept 23 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation Brownsville, Md.18. Funeral director J. H. Backles,Address Bolivar, W. Va.19. Sept 24 1945 Cornelia A. M. M.
(Date rec'd by registrar) Deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty WashingtonCity or town (If outside city or town limits, write RURAL NEAR and give town)Street No. Sandy Hook, Md. R.R. # 1

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

Lost

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1945, at 7:00 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Sept 21 1945, and that I last saw him alive on Sept 20 1945.Immediate cause of death Coronary ThrombosisDURATION 5000

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

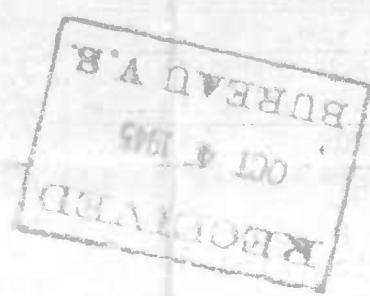
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury J. H. Backles Injured at work?23. SIGNATURE J. H. Backles

M. D. or other

Address BrunswickDate signed Sept 24 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09022

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 weeks

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?

5 weeks

3. (a) FULL NAME

Robert Monroe Mullinx

3. (b) Social Security Number

none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

8. (b) Name of husband or wife

Eccelia Mullinx

7. Birth date of deceased (mo., day, yr.)

Oct 4 1871

(c) If alive, give age

70

years

8. AGE:

78

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Montgomery Co. Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

John Joseph Mullinx

13. Birthplace

Montgomery Co. Md.

14. Maiden name

Eunice Hayes Purdum

15. Birthplace

Montgomery Co. Md.

16. Informant

Mrs. Purdum Poole

Address

Damascus, Md.

17. Burial

Date thereof Oct 7 1945

(Burial, cremation, or removal. Write in)

(month) (day) (year)

Cemetery or crematory

Mt. Lebanon

Location

Near Damascus

18. Funeral director

B. Seall, Inc.

Address

Damascus, Md.

19. (b) Death

1945

(Date rec'd by registrar)

Elizabeth G. Tech

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Damascus R.I.D.S.

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH September 5,

1945

at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 17, 1942, to September 5, 1945,

and that I last saw h.m. alive on August 29, 1945.

Immediate cause of death Arteriosclerotic gangrene

left leg.

DURATION

5 weeks

Due to Arteriosclerotic cardiovascular disease

15 years

Due to Cerebral thrombosis, right.

4 months

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James D. Kerr, M.D.

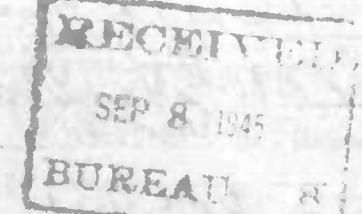
M. D. or other

Address Damascus, Md.

Date signed 9/6/45

MEMORANDUM TO: SECRETARY OF STATE CAGYMAN

MEMORANDUM FROM: DEPARTMENT OF STATE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

CERTIFICATE OF DEATH

09023
Reg. Dist. No. 139

1. PLACE OF DEATH:

County **Frederick**City or town **State Sanatorium, Maryland**
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? **Since 9/26/45**Hospital, Institution, or street address where death occurred: **Maryland Tuberculosis Sanatorium**How long in hospital or institution? **Since 9/26/45**

3. (a) FULL NAME

Henry Porach

4. Sex

5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Single**

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) **Sept. 27, 1910** 6. (c) If alive, give age years8. AGE: Years **35** Months **0** Days **0** If less than one day hrs. min.9. Birthplace **Baltimore, Maryland**
(Town, county, and state)10. Usual occupation **Shipyard Worker**

11. Industry or business

FATHER 12. Name **Joseph Porach**13. Birthplace **Czechoslovakia**MOTHER 14. Maiden name **Susion Mikula**15. Birthplace **Czechoslovakia**16. Informant **Mrs. Mary Burke (Sister)**Address **1125 Rosedale Ave., Balto., Md.**17. Burial Date thereof **10/2/45**
(Burial, cremation, or removal. Which?)Cemetery **St. Stanislaus**
Location **Baltimore, Maryland**18. Funeral director **M. L. Creager & Son**Address **Thurmont, Maryland**19. **9/27** 19. **45**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State **Maryland** CountyCity or town **Baltimore**
(If outside city or town limits, write RURAL and give nearest town)Street No. **4330 E. Lombard**
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH **September 27** 19 **45** at **8 P.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **September 26** 19 **45** to **Sept. 27** 19 **45** and then I last saw him alive on **September 27** 19 **45**.Immediate cause of death **Pulmonary Tuberculosis** DURATION **2 1/2 Yrs.**xxxx **Laryngeal Tuberculosis** UNKNOWN

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

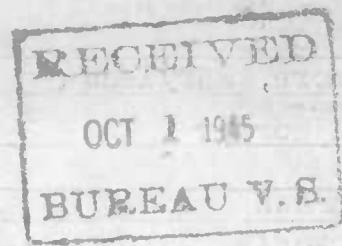
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **J. K. Dyer** M.D. **Exxx**Address **State Sanatorium, Md.** Date signed **9/28/45**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

09024

CERTIFICATE OF DEATH

Reg. Distr. No. 144

1. PLACE OF DEATH:
County..... Frederick
City or town..... Thurmont - Rural R. F. D. #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 2 Months
Hospital, institution, or street address where death occurred:..... Lewistown
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Frederick
City or town..... Thurmont - Rural R. F. D. #1
(If outside city or town limits, write RURAL and give nearest town)
Street No..... Lewistown
(If rural, give LOCATION)
2.(a) If veteran, name war..... None

3. (a) FULL NAME
CHARLES NEWTON REEDER

4. Sex..... M 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... W

6.(b) Name of husband or wife..... Cora Emma Twenty

7. Birth date of deceased (mo., day, yr.)..... 6.(c) If alive, give age..... years
February 14, 1867

8. AGE: Years..... 78 Months..... 6 Days..... 19 If less than one day..... hrs. min.

9. Birthplace..... Nr. Middletown-Frederick-Maryland
(Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business
MOTHER / FATHER..... Josephus Reeder
12. Name..... 13. Birthplace..... Frederick County Maryland

MOTHER..... Mary Ann Bere
14. Maiden name..... 15. Birthplace..... Frederick County Maryland

16. Informant..... Raymond N. Reeder
Address..... Thurmont, Maryland R. F. D. #1

17. Burial..... Date thereof..... 9/6/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Rocky Springs Cemetery

Location..... Near Frederick, Maryland

18. Funeral director..... M. R. Etchison and Son
Address..... Frederick, Maryland

19. H. Dept..... 1945
(Date rec'd by registrar)

3. (b) Social Security Number..... None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 3, 1945, at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1, 1941, to Sept 3, 1945
and that I last saw h. m. alive on Sept 3, 1945

Immediate cause of death.....

Due to..... Henry Ligin
Cause of death..... Cardio-Vascular Disease

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

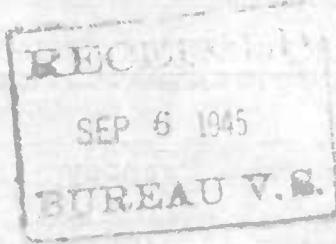
Injured at work?

23. SIGNATURE..... H. Lawrence Faloney, M. D.

M. D. or other.....

Address..... Frederick, Maryland Date signed..... 9-4-45

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 994

CERTIFICATE OF DEATH

19025

Reg. Dist. No.

131

1. PLACE OF DEATH:

County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?

3. (a) FULL NAME

CHARLES HENRY CRAMER RHODERICK

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

8. (b) Name of husband or wife Anna W. Rhoderick

7. Birth date of deceased (mo. day, yr.) September 19, 1871

8. AGE: Years Months Days It less than one day
73 11 17 hrs. min.9. Birthplace Mt. Pleasant, Maryland
(Town, county, and state)

10. Usual occupation Retired Letter Carrier

11. Industry or business None

12. Name John Rhoderick

13. Birthplace Mt. Pleasant, Md.

14. Maiden name Catherine Ann Sponsellor

15. Birthplace New Market, Maryland

16. Informant Mrs. Charles H. C. Rhoderick

Address Frederick, Maryland

17. Burial Date thereof Sep. 8, 1945
(Burial, cremation, or removal when?)

Cemetery or cemetery Mt. Olivet Cemetery

Location Frederick, Maryland

18. Funeral director C. E. Cline & Son

Address Frederick, Maryland

19. 7-Dept Date rec'd by registrar 1945

Elizabeth G. Heck
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 127 East Third Street

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1945, at 3:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 1945, to Sept. 6 1945 and that I last saw him alive on Sept. 6 1945

Immediate cause of death

Coronary Thrombosis

Due to Chronic Myocarditis

Due to

Other conditions Bronchial Pneumonia

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

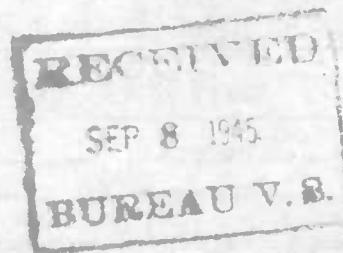
Injured at work?

23. SIGNATURE

Howard W. Cline M.D.

M. D. or other

Address Frederick, Md. Date signed 9-7-45.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09026

Reg. Dist. No. 131

1. PLACE OF DEATH

County Frederick

City Mt. Pleasant, Fred., Md. R.D.1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Samuel William Rideout

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

colored

widower

6. (b) Name of husband or wife

Emma Minor

7. Birth date of deceased (mo., day, yr.)

April 17, 1890

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

50

5

22

hrs.

min.

9. Birthplace

Mt. Pleasant, Frederick, Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Edward R. Rideout,

MOTHER FATHER

Mt. Pleasant, Md.

13. Birthplace

Mary Millbury,

14. Maiden name

Carroll Co., Md.

15. Birthplace

Mary Keys,

16. Informant

Chapel Alley, Frederick, Md.

Address

Burial

Sept. 12, 45

17. (Burial, cremation, or removal, where)

Date thereof (month) (day) (year)

Cemetery or crematory St. Peters Cemetery,

Location Libertytown, Md.

18. Funeral director

M. R. Etchison & Son,

Frederick, Md.

Address

19. II Sept

1945

Elizabeth L. Hecke.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Frederick

City ~~down~~

Mt. Pleasant, Fred., Md. R.D.1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

210-14-8979

MEDICAL CERTIFICATION

Sept. 9th.,

45

8.30P

20. DATE OF DEATH

and that I last saw him alive on Sept 9

Immediate cause of death.

Fracture of skull
fracture of left arm
Due to & at age 71

DURATION

Sunday

Due to

Auto accident

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

Mt Pleasant

County

(State)

Injured at home, farm, industry, public place (where)

Route II-26

Means of injury

Auto

Injured at work

B. Thomas Deputy Med Ex

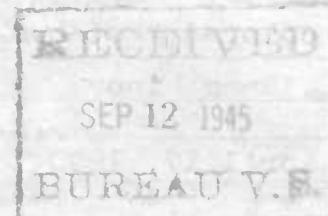
23. SIGNATURE

M. D. or other

Frederick, Md. Dep. Medical Examiner

Date signed

9/17/45



PLEASE WRITE PLAINLY, WITH ~~LINE~~ FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09027

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick

Frederick

City or town (If outside city or town limits, write RURAL and give nearest town)

13 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?

13 days

3. (a) FULL NAME

WILLIAM HOWARD ROPP

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) September 5, 1945

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

0

0

13

hrs.

min.

9. Birthplace Frederick-Frederick-Maryland

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

William F. Simpson

MOTHER FATHER

13. Birthplace Texas

MOTHER

14. Maiden name Margaret G. Ropp

FATHER

15. Birthplace Frederick County Maryland

16. Informant

Margaret G. Ropp

Address

R. F. D. #5, Frederick, Md.

17. Burial

Date thereof 9/19/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Rocky Spring Cemetery

Location Near Frederick, Maryland

18. Funeral director

M. R. Etchison and Son

Address

Frederick, Maryland

19. (Signature)

19-45

Elizabeth H. Heck
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

Frederick

State

County

City or town

Frederick-Rural R. F. D. #5

Street No.

Shookstown

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18, 1945 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 5 1945 to Sept 18 1945

and that I last saw him alive on Sept 16 1945

Immediate cause of death

Lobar pneumonia

DURATION

4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. Lawrence Zahony M. D.

M. D. or other

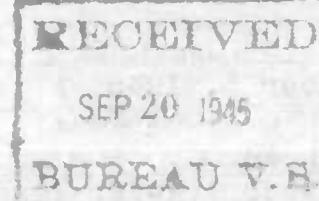
Address

Frederick, Maryland Date signed 9-19-45

STICK TO YOUR STATE GUARDIAN

DO NOT REMOVE

RETAIN TO STATE GUARDIAN



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09028

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

Frederick
County.....State Sana torium, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 3/15/45

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sana torium

How long in hospital or institution? Since 3/15/45

3. (a) FULL NAME

John P. Ross

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced
Male White Single6. (b) Name of husband or wife.....
7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age.....years
March 17, 18898. AGE: Years Months Days It less than one day
56 6 0 hrs. min.9. Birthplace.....
(Town, county, and state)
Baltimore, Md.10. Usual occupation.....
Baker

11. Industry or business.....

12. Name.....
Patrick Ross13. Birthplace.....
Ireland14. Maiden name.....
Ellen Kenny15. Birthplace.....
Ireland16. Informant.....
Deceased

Address.....

17. Burial.....
(Burial, cremation, or removal, which?)
Date thereof.....
(month) (day) (year)
Sept. 24, 1945Cemetery or place.....
New (or old) CathedralLocation.....
Baltimore, Md.18. Funeral director.....
M. L. Creager & SonAddress.....
Thurmont, Maryland19. (Date rec'd by registrar).....
9/17/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No..... 2720 Cylburn Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

218-14-9324

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 17 1945, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 15 1945, to Sept. 17 1945
and that I last saw him alive on September 17 1945

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

11 Mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

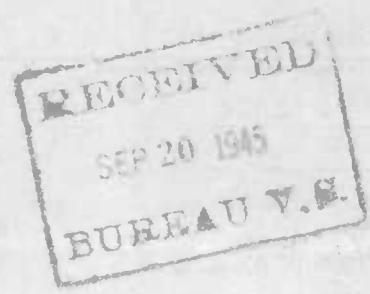
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. xxxxxx

Address..... State Sana torium, Md. Date signed 9/18/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131

09029

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: Endersick
County: FrederickCity or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Frederick City Hospital

How long in hospital or institution?

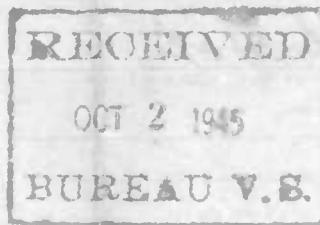
3. (a) FULL NAME Patricia Snoots4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced -6. (b) Name of husband or wife: -7. Birth date of deceased (mo., day, yr.) June 12th 1945 6. (c) If alive, give age years8. AGE: Years 3 Months 15 Days - If less than one day - hrs. - min. -9. Birthplace Frederick City Hospital
(Town, county, and state)10. Usual occupation: -11. Industry or business -12. Name Wilbur C Snoots
13. Birthplace MD14. Maiden name Patricia J Payne
15. Birthplace MD16. Informant Wilbur C Snoots
Address Petersville MD17. Burial Burial (Burial, cremation, or removal) Date thereof Sept 29/45
(month) (day) (year)Cemetery or Endersick Location new st of Roads MD18. Funeral director OTter 3272 9/21
Address Brunswick19. 27-Dept 1945 (Date rec'd by registrar) Eligible by Heck,
Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State: MD County: Frederickor town: Petersville (If outside city or town limits, write RURAL and give nearest town)Street No. - (If rural, give LOCATION) none2. (a) If veteran, name war: none3. (b) Social Security Number none

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1945 at 11:45 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 24 to Sept 27, 1945, and that I last saw her alive on Sept 27, 1945.Immediate cause of death Thrush - Maternal DURATION 1 moDue to Postnatal Infection DURATION 6 hrsDue to Thrush DURATION 2 wksOther conditions Prenatal DURATION birth
(Include pregnancy within 8 months of death)Major findings of operations: Date of op. -

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide: - Date of -Where did injury occur? - (City or town) (County) (State) -Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE J. C. Bruce M. D. or other Jefferson MD M. D. or other 9/27/45Address - Date signed 9/27/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2400

09030

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:

County FrederickCity or town Rural - Brunswick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 mos.

Hospital, institution, or street address where death occurred:

Summer camp on Potomac River

How long in hospital or institution?

3. (a) FULL NAME

Lewis Edward Spurrier.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M W Married6. (b) Name of husband or wife Annie May MoxleyB. (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) June 23, 18808. AGE: Years 65 Months 2 Days 10 If less than one day

hrs. min.

B. Birthplace Plane #4, Fred. Co., Md.

(Town, county, and state)

10. Usual occupation Retired Locomotive Engineer.

11. Industry or business

MOTHER FATHER 12. Name George W Spurrier.13. Birthplace Plane #4, Fred. Co., Md.14. Maiden name Sarah Emma Rippion15. Birthplace Plane #4, Fred. Co., Md.16. Informant Mrs. Lewis E. SpurrierAddress 328 Brunswick St. Brunswick, Md.17. Burial Date thereof Sept 4 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or cremator Marrin ChapelLocation Plane #4, Fred. Co., Md.18. Funeral director George S. BaileyAddress 320 W. Potomac St. Brunswick, Md.19. Death 4- Date rec'd by registrar 1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

FrederickCity or town Brunswick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 328 Brunswick St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

705-10-0001

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 4 1945 at 4:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1 46 to Sept 2 46 1945and that I last saw him alive on Aug 30 46 1945

Immediate cause of death

Coronary Thrombosis DURATION 30 MO

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

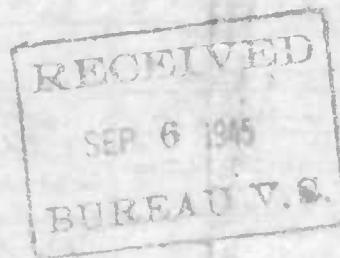
Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Lewis Spurrier M. D. or otherAddress Brunswick, Md. Date signed Sept 4 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

09031 131

Reg. Dist. No.

1. PLACE OF DEATH:

County Frederick

City or town Frederick (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred: Frederick City Hospital

How long in hospital or institution? 1 month

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

B.(b) Name of husband or wife:

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 10 - 1941

8. AGE:

Years	Months	Days	if less than one day
4	5	22	hrs. min.

9. Birthplace

Carroll County, Maryland

(Town, county and state)

10. Usual occupation:

11. Industry or business

None

MOTHER

12. Name

Raymond W. Stevens

13. Birthplace

Maryland

14. Maiden name

Martha Fogle

15. Birthplace

Maryland

16. Informant

Raymond W. Stevens

Address

Mt. airy Maryland - R. 1

17. Burial

Cremation Date thereof Sept 4 - 1943
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Mount Zion

Location

Mc Kees - Maryland

18. Funeral director

Donald & Hart

Address

Woodlawn & Libertyland Maryland

19. 3-Death

1945

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 9 1945 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 1945 to Sept 9 1945

and that I last saw him alive on Sept 9 1945

Immediate cause of death

Diseases of heart, heart attack

Due to

Diseases of heart, heart attack

Due to

Diseases of heart, heart attack

Other conditions

Diseases of heart, heart attack

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

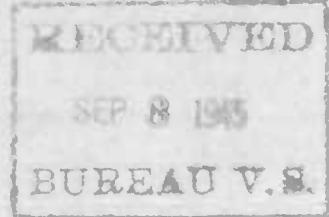
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Holmesville Date signed Sept 2



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

9032

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick

City or town State Sanatorium, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 6/12/45

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Since 6/12/45

3. (a) FULL NAME

Dorothy W. Tignor

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1903
6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

41

11

16

hrs.

min.

9. Birthplace Tyaskin, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Maurice Willing

13. Birthplace Tyaskin, Md.

MOTHER 14. Maiden name Mary Anna Travers

15. Birthplace White Haven, Md.

16. Informant Mary Anna Tignor (Daughter)

Address 2911 Onyx Rd., Parkville, Md.

17. Removal Sept. 17, 1945
(Burial, cremation, or removal? Which?)

Date thereof (month) (day) (year)

Cemetery or crematory Thurmont St. Marys

Location Tyaskin, Md.

18. Funeral director M. L. Greager & Son

Address Thurmont, Md.

19. 9/16/45
(Date rec'd by registrar)

19. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Quantico
(If outside city or town limits, write RURAL and give nearest town)Street No. R. 1
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16 1945, at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 12, 1945, to Sept. 16, 1945, and that I last saw her alive on September 16, 1945.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

5 Mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

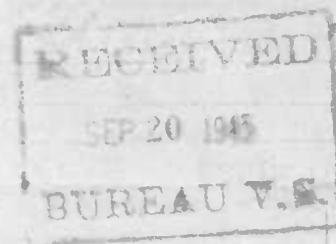
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. B. Lyon M. D. Doctor

Address State Sanatorium, Md. Date signed 9/17/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 

09033

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County

Frederick

City or town

Walkersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

29 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles H. Trout

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

married

B. (b) Name of husband or wife

Lora Andes Trout

7. Birth date of deceased (mo., day, yr.)

Aug 18, 1862

B. (c) If alive, give age 73 years

8. AGE:

Years

Months

Days

If less than one day

83

1

12

hrs.

min.

9. Birthplace

Front Street, Fred. Co., Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

John Trout

12. Name

Fred. Co.

13. Birthplace

Catherine Dorcas

14. Maiden name

The & Co.

15. Birthplace

Mrs Harry S. Smith

16. Informant

Walkersville, Md.

Address

17. Burial

Burial

Date thereof Oct 2, 1945
(month) (day) (year)

(Burial, cremation, or removal. Where?)

Cemetery or crematory

Mt Hope

Location

Woodsboro, Md.

18. Funeral director

G. C. Barton

Address

Walkersville

19. (a) Date

1945

(Date rec'd by registrar)

Elizabeth G. Heck.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Frederick

City or town

Walkersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 30

1945, af. 230 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 15, 1945, to Sept 30, 1945
and that I last saw him alive on Sept 30, 1945

Immediate cause of death

Apoplexy

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

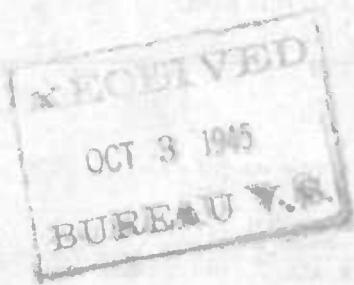
Elizabeth Heck

N. D. or other

Address

Walkersville, Md.

Date signed Oct. 45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

134

CERTIFICATE OF DEATH

Reg. Dist. No. 134

1. PLACE OF DEATH:

County FrederickCity or town Rural. Emmitsburg, R.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

about 1 mile west

How long in hospital or institution?

3. (a) FULL NAME

Harry Grant Wantz4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Sallie Caldwell Wantz7. Birth date of deceased (mo., day, yr.) Feb. 8, 1890 6. (c) If alive, give age 55 years8. AGE: Years 55 Months 4 Days 7 If less than one day hrs. _____ min. _____9. Birthplace Adams County, Penna. (Town, county, and state)10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John R. Wantz13. Birthplace Frederick Co., Md.MOTHER 14. Maiden name Sallie Caldwell15. Birthplace Adams Co., Pa.16. Informant mrs annie E. WantzAddress Emmitsburg, R.D., Md.17. Burial Emmitsburg, R.D., Md. Date thereof Sept. 15, 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. View CemeteryLocation Emmitsburg, Md.18. Funeral director J. L. AllisonAddress Emmitsburg, Md.19. Sept. 13 1945 (Date rec'd by registrar)

M. F. Shuff Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Rural (If outside city or town limits, write RURAL and give nearest town)Street No. Emmitsburg, Md. R.D. (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 12, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1, 1942, to Sept. 12, 1945
and shall last saw him alive on Sept. 2, 1945

Immediate cause of death

cardi. dilatation
of heartDue to this man died in
one or two monthsDue to after exertion of walking
uphill three or four

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

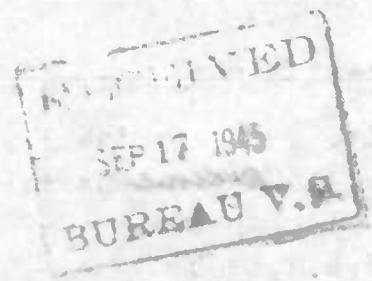
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ira M. Henderson, M.D.
M. D. or other
Address Fairfield, Pa. Date signed Sept. 13-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

09035

Reg. Dist. No. 145

1. PLACE OF DEATH:
 County Frederick
 City or town Rural (Myersville)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 65 yr.
 Hospital, institution, or street address where death occurred:
Pleasant Walk
 How long in hospital or institution? —

3. (a) FULL NAME

Virgie B. Warrenfeltz3. (b) Social Security Number —

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Marshall H. Warrenfeltz
 7. Birth date of deceased (mo., day, yr.) March 16 1880 8. (c) If alive, give age 70 year
 8. AGE: Years 65 Months 5 Days 15 If less than one day hrs. 00 min.
 9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Hairdressing
 11. Industry or business Home
 MOTHER FATHER 12. Name Jessiech Betty
 13. Birthplace Maryland
 14. Maiden name Anna Dreyer
 15. Birthplace Maryland
 16. Informant Marshall H. Warrenfeltz
 Address Myersville Md.
 17. (Burial, cremation, or removal. Which?) Burial Date thereof Sept 5 1945
 Cemetery or crematory Pleasant Walk
 Location Rural Myersville Md.
 18. Funeral director C. H. Felt & Son
 Address Brunswick Md.
 18. Sept 4 1945 Degay Betty
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Frederick
 City or town (Rural) Myersville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Pleasant Walk
 (If rural, give LOCATION)

2. (a) If veteran, name war —

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1945 at 7:30A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19and that I last saw him alive on 19

Immediate cause of death

Chronic Myxedema -

Due to

Hydrocephalus of right kidney

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State) —Injured at home, farm, industry, public place (where?) —

Means of injury

Injured at work? —23. SIGNATURE J. W. Kirby M.D.

M. D. or other

Address Boonsboro Date signed 9/2/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09036 131

Reg. Dist. No.

1. PLACE OF DEATH:
County Frederick

City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 6 mo.

3. (a) FULL NAME

Allie May Whipp

4. Sex F 5. Color or race 21 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife George Whipp 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22. 1877

8. AGE: Years 67 Months 11 Days 29 If less than one day hrs. min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business Own home

FATHER 12. Name Elvira

MOTHER 13. Birthplace Frederick Co. Md.

14. Maiden name Susan Roots

15. Birthplace Frederick Co. Md.

16. Informant Charles Roots

Address Hampstead Md.

17. Burial Date thereof Sept. 24 1945
(Burial, cremation, or removal. Which?) Date (month) (day) (year)

Cemetery or cemetery Mt. Hope Cemetery

Location Woodsboro Md.

18. Funeral director Burke & Hartley

Address Woodsboro Md.

19. Date rec'd by registrar Sept. 22 1945 Elizabeth G. Heek
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 S. Third St.
(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945 to Sept 21 1945 and that I last saw her alive on Sept 21 1945

Immediate cause of death Paroxysmal stomach

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

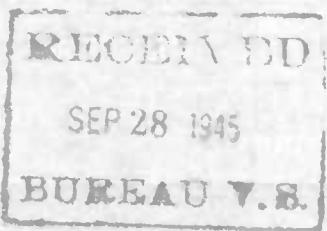
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

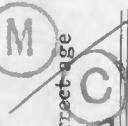
23. SIGNATURE Paul L. Costley M. D. or other

Address Wolftown, Md. Date signed Sept 22 1945





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B7

09037

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH:
County... **Frederick**

City or town... **Frederick** - **Rural**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **7 days**

Hospital, institution, or street address where death occurred:
Frederick County Emergency Hospital

How long in hospital or institution?

3. (a) FULL NAME
Charles Edward Wills

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Single
-----------------------	----------------------------------	---

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) **September 3, 1945**

8. AGE: Years **0** Months **0** Days **7** If less than one day
hrs. min.

9. Birthplace **Frederick, Md.**
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER
12. Name **John Richard Wills**
13. Birthplace **Frederick, Md.**

MOTHER
14. Maiden name **Dorothy Virginia Schultz**
15. Birthplace **Frederick Co., Md.**

16. Informant **Mr. John Richard Wills**
Address **213 East Fourth St., Fred., Md.**

17. Burial
(Burial, cremation, or removal, which)
Date thereof **9/11/45**
(month) (day) (year)

Cemetery or crematory **Mt. Olivet Cemetery**

Location **Frederick, Md.**
18. Funeral director **M. R. Etchison & Son**

Address **Frederick, Md.**

19. **11-Sept** 1945
(Date rec'd by registrar)

Elysbeth G. Heck
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **Maryland** County **Frederick**

City or town **Frederick**
(If outside city or town limits, write RURAL and give nearest town)

Street No. **213 East Fourth Street**
(If rural, give LOCATION)

2. (a) If veteran, name war **NONE**

3. (b) Social Security Number
✓

MEDICAL CERTIFICATION

20. DATE OF DEATH **September 10, 1945** at **4:30 p.m.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 3 1945 to **Sept 10** 1945
and that I last saw him **alive** on **Sept 10** 1945

Immediate cause of death.....

Premature birth

Due to.....

Exhaustion

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

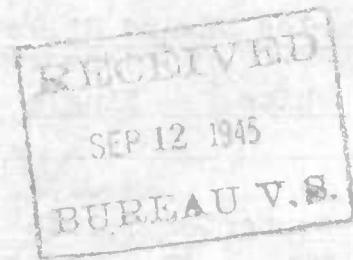
Means of injury.....

Injured at work?

23. SIGNATURE **J. Lawrence Faherty M.D.**

M.D. or other

Date signed **9/11/45**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-3

CERTIFICATE OF DEATH

Reg. Dst. No. 134

1938

1. PLACE OF DEATH: *Frederick*
County *Summitburg*

City or town *Summitburg*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *5 days*
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME *Anthony Augustin Wirell*

4. Sex *Male* 5. Color of race *White* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Anna C. Sanders*

7. Birth date of deceased (mo., day, yr.) *Aug 13 - 1865* 6. (c) If alive, give age *years*

8. AGE: Years *80* Months *19* Days *19* If less than one day *hrs. 00* min. *00*

9. Birthplace *Summitburg Md* (Town, County, and state)

10. Usual occupation *Retired*

11. Industry or business *Matt. Wirell*

FATHER 12. Name *Matt. Wirell*

13. Birthplace *Summitburg*

MOTHER 14. Maiden name *Francesca L. Baker*

15. Birthplace *Summitburg Md*

16. Informant *Joseph Wirell*

Address *Summitburg Md*

17. (Burial, cremation, or removal? When?) *Burial Sept 5-1945* Date thereof *(month) (day) (year)*

Cemetery or crematory *St. Joseph's Cemetery*

Location *Summitburg Md*

18. Funeral director *M. F. Caesar Jr.*

Address *Thurmont Md*

19. (Date rec'd by registrar) *Sept 4 1945* M. F. Shultz

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State *Md* County *Frederick*

City or town *Summitburg* (If outside city or town limits, write RURAL and give nearest town)

Street No. *Summitburg* (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number *None*

MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 2 1945* at *9 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1926* to *Sept 2 1945*

and that I last saw him alive on *Sept 1 1945*

Immediate cause of death *arterio sclerotic cardio*

vascular disease

Due to *with hypertension - several years*

Due to

Other conditions *Cerebral hemorrhage - 2 years*

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *W. R. Cade Md*

M. D. or other

Address *Summitburg Md* Date signed *9-3-45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

69039

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County..... Frederick

City or town..... State Sanatorium, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Since 8/8/45

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Since 8/8/45

How long in hospital or institution?.....

3. (a) FULL NAME

Catherine Yeakle

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband ~~W.E.~~ Howard Yeakle7. Birth date of deceased (mo. day, yr.) Nov. 18, 1901
6.(c) If alive, give age 47 years8. AGE: Years Months Days If less than one day
43 10 4 hrs. min.9. Birthplace..... Baltimore, Maryland
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

MOTHER FATHER 12. Name..... William Chilcote

13. Birthplace..... Maryland

14. Maiden name..... Sara Dillahunt

15. Birthplace..... Baltimore, Md.

16. Informant..... Howard Yeakle (Husband)

Address 2306 Robb St., Baltimore, Md.

17. Burial..... Date thereof 9/25/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery ~~W.E.~~ Lorraine

Location..... Baltimore, Maryland

18. Funeral director..... M. L. Creager & Son

Address..... Thurmont, Maryland

19. (Date rec'd by registrar) 9/23/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No..... 2306 Robb St.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 22 1945, at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 8 1945, to Sept. 22, 1945,

and that I last saw her alive on September 22, 1945.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

1 Yr

Disease.....

Tuberculous Enteritis

6 Mos

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

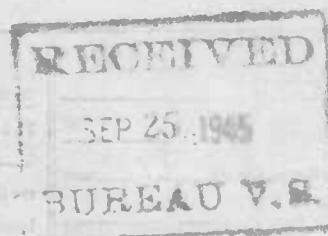
Means of Injury.....

Injured at work?

23. SIGNATURE..... *J. B. E.*

M. D. YEAKLE

Address..... State Sanatorium, Md. Date signed 9/23/45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

119040

Reg. Dist. No. 138

1. PLACE OF DEATH:
County **Frederick**
City or town **Mount Airy-Rural R. F. D. #1**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **9 Years**
Hospital, institution, or street address where death occurred:
Barthlows
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State **Maryland** County **Frederick**
City or town **Mount Airy-Rural R. F. D. #1**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **Barthlows**
(If rural, give LOCATION)
2.(a) If veteran, name war.....
None

3. (a) FULL NAME
JULIA AGNES YOUNG

3. (b) Social Security Number
None

4. Sex F	5. Color or race W	6.(a) Single, married, widowed, or divorced M
-----------------	---------------------------	--

6.(b) Name of husband or wife **Homer G. Young**
6.(c) If alive, give age **54** years
7. Birth date of deceased (mo., day, yr.) **February 23, 1895**

8. AGE: Years 50	Months 7	Days 7	If less than one day hrs. min.
-------------------------	-----------------	---------------	--

9. Birthplace **Pearl-Frederick-Maryland**
(Town, county, and state)

10. Usual occupation **House-Wife**
At Home

11. Industry or business **Albert W. Phelps**

MOTHER FATHER
12. Name **Frederick County Maryland**

13. Birthplace **Susanna Elizabeth McDonald**

14. Maiden name **Frederick County Maryland**

15. Birthplace **Mr. Homer G. Young**

16. Informant **Mount Airy, Md. R. F. D. #1**
Address

17. Burial **10/3/45**
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Frederick Memorial Park

Cemetery or crematory **Frederick, Maryland**
Location

18. Funeral director **M. R. Etchison and Son**
Address

19. **1- Oct** 1945 - **Lillian K. Falconer**
(Date rec'd by registrar) **Registrar**

MEDICAL CERTIFICATION
2D. DATE OF DEATH **September 30, 1945, at 8:30A M**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **19. to 19.**
and that I last saw **him alive** **September 30, 1945**

Immediate cause of death **Coronary occlusion**
DURATION **1 hr**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

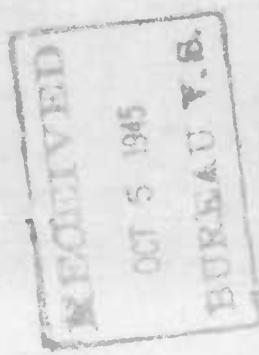
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE **Baptist Medical Center** **10-1-45**
M.D. or other
Address **Frederick, Maryland** Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20201

CERTIFICATE OF DEATH

1941

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 82 years

Hospital, institution, or street address where death occurred:

118 West 3rd StHow long in hospital or institution? None

3. (a) FULL NAME

Georgia Whaley Zimmerman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female white widowed6. (b) Name of husband or wife W. H. Zimmerman

7. Birth date of deceased (mo., day, yr.)

Jan 18, 1863

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
82	8	1	hrs. min.

9. Birthplace

Frederick, Frederick, Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None12. Name George W. Whaley13. Birthplace Martinsburg, W. Virginia14. Maiden name Leahela Wagner15. Birthplace Frederick, Co. Md16. Informant Miss Leahela ZimmermanAddress Frederick, Md.17. Burial Date thereof 9/22/45

(Burial, cremation, or removal, which)

Cemetery or crematory Mt. OlivetLocation Frederick, Md.18. Funeral director Harry E. Gandy CoAddress Frederick, Md.19. Rec'd. - Dept. 1945

(Date rec'd by registrar)

Elizabeth G. Hecke

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 118 West 3rd St

(If rural, give LOCATION)

2. (a) If veteran, name war

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 19 1945 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1945 to Sept. 19 1945 and that I last saw her alive on Sept. 19 1945

Immediate cause of death

Cerebral Hemorrhage

Due to

SenilityOther conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings or operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. Gustav Pearce, M.D.

M. D. or other

Address Frederick, Md. Date signed 9/25/45

RECEIVED

SEP 22 1945

BUREAU F.B.I.